

SENATE SUBSTITUTE

FOR

SENATE BILL NO. 1

AN ACT

To repeal sections 190.839, 198.439, 208.152, 208.437, 208.480, 338.550, and 633.401, RSMo, and to enact in lieu thereof seven new sections relating to MO HealthNet.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Sections 190.839, 198.439, 208.152, 208.437, 208.480, 338.550, and 633.401, RSMo, are repealed and seven new sections enacted in lieu thereof, to be known as sections 190.839, 198.439, 208.152, 208.437, 208.480, 338.550, and 633.401, to read as follows:

190.839. Sections 190.800 to 190.839 shall expire on September 30, ~~[2021]~~ 2024.

198.439. Sections 198.401 to 198.436 shall expire on September 30, ~~[2021]~~ 2024.

208.152. 1. MO HealthNet payments shall be made on behalf of those eligible needy persons as described in section 208.151 who are unable to provide for it in whole or in part, with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Inpatient hospital services, except to persons in an institution for mental diseases who are under the age of sixty-five years and over the age of twenty-one years; provided that the MO HealthNet division shall provide through rule and regulation an exception process for coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional

activities study (PAS) or the MO HealthNet children's diagnosis length-of-stay schedule; and provided further that the MO HealthNet division shall take into account through its payment system for hospital services the situation of hospitals which serve a disproportionate number of low-income patients;

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such services, determined in accordance with the principles set forth in Title XVIII A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301, et seq.), but the MO HealthNet division may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the MO HealthNet division not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for participants, except to persons with more than five hundred thousand dollars equity in their home or except for persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the department of health and senior services or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX of the federal Social Security Act (42 U.S.C. Section 301, et seq.), as amended, for nursing facilities. The MO HealthNet division may recognize through its payment methodology for nursing facilities those nursing facilities

49 which serve a high volume of MO HealthNet patients. The MO
50 HealthNet division when determining the amount of the
51 benefit payments to be made on behalf of persons under the
52 age of twenty-one in a nursing facility may consider nursing
53 facilities furnishing care to persons under the age of
54 twenty-one as a classification separate from other nursing
55 facilities;

56 (5) Nursing home costs for participants receiving
57 benefit payments under subdivision (4) of this subsection
58 for those days, which shall not exceed twelve per any period
59 of six consecutive months, during which the participant is
60 on a temporary leave of absence from the hospital or nursing
61 home, provided that no such participant shall be allowed a
62 temporary leave of absence unless it is specifically
63 provided for in his plan of care. As used in this
64 subdivision, the term "temporary leave of absence" shall
65 include all periods of time during which a participant is
66 away from the hospital or nursing home overnight because he
67 is visiting a friend or relative;

68 (6) Physicians' services, whether furnished in the
69 office, home, hospital, nursing home, or elsewhere;

70 (7) Subject to appropriation, up to twenty visits per
71 year for services limited to examinations, diagnoses,
72 adjustments, and manipulations and treatments of
73 malpositioned articulations and structures of the body
74 provided by licensed chiropractic physicians practicing
75 within their scope of practice. Nothing in this subdivision
76 shall be interpreted to otherwise expand MO HealthNet
77 services;

78 (8) Drugs and medicines when prescribed by a licensed
79 physician, dentist, podiatrist, or an advanced practice
80 registered nurse; except that no payment for drugs and
81 medicines prescribed on and after January 1, 2006, by a

82 licensed physician, dentist, podiatrist, or an advanced
83 practice registered nurse may be made on behalf of any
84 person who qualifies for prescription drug coverage under
85 the provisions of P.L. 108-173;

86 (9) Emergency ambulance services and, effective
87 January 1, 1990, medically necessary transportation to
88 scheduled, physician-prescribed nonelective treatments;

89 (10) Early and periodic screening and diagnosis of
90 individuals who are under the age of twenty-one to ascertain
91 their physical or mental defects, and health care,
92 treatment, and other measures to correct or ameliorate
93 defects and chronic conditions discovered thereby. Such
94 services shall be provided in accordance with the provisions
95 of Section 6403 of P.L. 101-239 and federal regulations
96 promulgated thereunder;

97 (11) Home health care services;

98 (12) Family planning as defined by federal rules and
99 regulations; provided, however, that such family planning
100 services shall not include abortions or any abortifacient
101 drug or device that is used for the purpose of inducing an
102 abortion unless such abortions are certified in writing by a
103 physician to the MO HealthNet agency that, in the
104 physician's professional judgment, the life of the mother
105 would be endangered if the fetus were carried to term;

106 (13) Inpatient psychiatric hospital services for
107 individuals under age twenty-one as defined in Title XIX of
108 the federal Social Security Act (42 U.S.C. Section 1396d, et
109 seq.);

110 (14) Outpatient surgical procedures, including
111 presurgical diagnostic services performed in ambulatory
112 surgical facilities which are licensed by the department of
113 health and senior services of the state of Missouri; except,
114 that such outpatient surgical services shall not include

persons who are eligible for coverage under Part B of Title XVIII, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended, if exclusion of such persons is permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended;

(15) Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by his or her physician on an outpatient rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be rendered by an individual not a member of the participant's family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility.

Benefits payable for personal care services shall not exceed for any one participant one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time. Such services, when delivered in a residential care facility or assisted living facility licensed under chapter 198 shall be authorized on a tier level based on the services the resident requires and the frequency of the services. A resident of such facility who qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier level with the fewest services. The rate paid to providers for each tier of service shall be set subject to appropriations. Subject to appropriations, each resident of such facility who qualifies

for assistance under section 208.030 and meets the level of care required in this section shall, at a minimum, if prescribed by a physician, be authorized up to one hour of personal care services per day. Authorized units of personal care services shall not be reduced or tier level lowered unless an order approving such reduction or lowering is obtained from the resident's personal physician. Such authorized units of personal care services or tier level shall be transferred with such resident if he or she transfers to another such facility. Such provision shall terminate upon receipt of relevant waivers from the federal Department of Health and Human Services. If the Centers for Medicare and Medicaid Services determines that such provision does not comply with the state plan, this provision shall be null and void. The MO HealthNet division shall notify the revisor of statutes as to whether the relevant waivers are approved or a determination of noncompliance is made;

(16) Mental health services. The state plan for providing medical assistance under Title XIX of the Social Security Act, 42 U.S.C. Section 301, as amended, shall include the following mental health services when such services are provided by community mental health facilities operated by the department of mental health or designated by the department of mental health as a community mental health facility or as an alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system established in section 630.097. The department of mental health shall establish by administrative rule the definition and criteria for designation as a community mental health facility and for designation as an alcohol and drug abuse facility. Such mental health services shall include:

181 (a) Outpatient mental health services including
182 preventive, diagnostic, therapeutic, rehabilitative, and
183 palliative interventions rendered to individuals in an
184 individual or group setting by a mental health professional
185 in accordance with a plan of treatment appropriately
186 established, implemented, monitored, and revised under the
187 auspices of a therapeutic team as a part of client services
188 management;

189 (b) Clinic mental health services including
190 preventive, diagnostic, therapeutic, rehabilitative, and
191 palliative interventions rendered to individuals in an
192 individual or group setting by a mental health professional
193 in accordance with a plan of treatment appropriately
194 established, implemented, monitored, and revised under the
195 auspices of a therapeutic team as a part of client services
196 management;

197 (c) Rehabilitative mental health and alcohol and drug
198 abuse services including home and community-based
199 preventive, diagnostic, therapeutic, rehabilitative, and
200 palliative interventions rendered to individuals in an
201 individual or group setting by a mental health or alcohol
202 and drug abuse professional in accordance with a plan of
203 treatment appropriately established, implemented, monitored,
204 and revised under the auspices of a therapeutic team as a
205 part of client services management. As used in this
206 section, mental health professional and alcohol and drug
207 abuse professional shall be defined by the department of
208 mental health pursuant to duly promulgated rules. With
209 respect to services established by this subdivision, the
210 department of social services, MO HealthNet division, shall
211 enter into an agreement with the department of mental
212 health. Matching funds for outpatient mental health
213 services, clinic mental health services, and rehabilitation

services for mental health and alcohol and drug abuse shall be certified by the department of mental health to the MO HealthNet division. The agreement shall establish a mechanism for the joint implementation of the provisions of this subdivision. In addition, the agreement shall establish a mechanism by which rates for services may be jointly developed;

(17) Such additional services as defined by the MO HealthNet division to be furnished under waivers of federal statutory requirements as provided for and authorized by the federal Social Security Act (42 U.S.C. Section 301, et seq.) subject to appropriation by the general assembly;

(18) The services of an advanced practice registered nurse with a collaborative practice agreement to the extent that such services are provided in accordance with chapters 334 and 335, and regulations promulgated thereunder;

(19) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection to reserve a bed for the participant in the nursing home during the time that the participant is absent due to admission to a hospital for services which cannot be performed on an outpatient basis, subject to the provisions of this subdivision:

(a) The provisions of this subdivision shall apply only if:

a. The occupancy rate of the nursing home is at or above ninety-seven percent of MO HealthNet certified licensed beds, according to the most recent quarterly census provided to the department of health and senior services which was taken prior to when the participant is admitted to the hospital; and

b. The patient is admitted to a hospital for a medical condition with an anticipated stay of three days or less;

(b) The payment to be made under this subdivision shall be provided for a maximum of three days per hospital stay;

(c) For each day that nursing home costs are paid on behalf of a participant under this subdivision during any period of six consecutive months such participant shall, during the same period of six consecutive months, be ineligible for payment of nursing home costs of two otherwise available temporary leave of absence days provided under subdivision (5) of this subsection; and

(d) The provisions of this subdivision shall not apply unless the nursing home receives notice from the participant or the participant's responsible party that the participant intends to return to the nursing home following the hospital stay. If the nursing home receives such notification and all other provisions of this subsection have been satisfied, the nursing home shall provide notice to the participant or the participant's responsible party prior to release of the reserved bed;

(20) Prescribed medically necessary durable medical equipment. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(21) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses

which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(22) Prescribed medically necessary dental services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(23) Prescribed medically necessary optometric services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(24) Blood clotting products-related services. For persons diagnosed with a bleeding disorder, as defined in section 338.400, reliant on blood clotting products, as defined in section 338.400, such services include:

(a) Home delivery of blood clotting products and ancillary infusion equipment and supplies, including the emergency deliveries of the product when medically necessary;

(b) Medically necessary ancillary infusion equipment and supplies required to administer the blood clotting products; and

(c) Assessments conducted in the participant's home by a pharmacist, nurse, or local home health care agency trained in bleeding disorders when deemed necessary by the participant's treating physician;

(25) The MO HealthNet division shall, by January 1, 2008, and annually thereafter, report the status of MO HealthNet provider reimbursement rates as compared to one hundred percent of the Medicare reimbursement rates and compared to the average dental reimbursement rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by July 1, 2008, provide to the general assembly a four-year plan to achieve parity with Medicare reimbursement rates and for third-party payor average dental reimbursement rates. Such plan shall be subject to appropriation and the division shall include in its annual budget request to the governor the necessary funding needed to complete the four-year plan developed under this subdivision.

2. Additional benefit payments for medical assistance shall be made on behalf of those eligible needy children, pregnant women and blind persons with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Dental services;

(2) Services of podiatrists as defined in section 330.010;

(3) Optometric services as described in section 336.010;

(4) Orthopedic devices or other prosthetics, including eye glasses, dentures, hearing aids, and wheelchairs;

(5) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(6) Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive, and behavioral function. The MO HealthNet division shall establish by administrative rule the definition and criteria for designation of a comprehensive day rehabilitation service facility, benefit limitations and payment mechanism. Any rule or portion of a rule, as that term is

defined in section 536.010, that is created under the authority delegated in this subdivision shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2005, shall be invalid and void.

3. The MO HealthNet division may require any participant receiving MO HealthNet benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered services except for those services covered under subdivisions (15) and (16) of subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. Section 1396, et seq.) and regulations thereunder. When substitution of a generic drug is permitted by the prescriber according to section 338.056, and a generic drug is substituted for a name-brand drug, the MO HealthNet division may not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods or services described under this section must collect from all participants the additional payment that may be required by the MO HealthNet division under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by participants under this section shall be in addition to and

not in lieu of payments made by the state for goods or services described herein except the participant portion of the pharmacy professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time a service is provided or at a later date. A provider shall not refuse to provide a service if a participant is unable to pay a required payment. If it is the routine business practice of a provider to terminate future services to an individual with an unclaimed debt, the provider may include uncollected co-payments under this practice. Providers who elect not to undertake the provision of services based on a history of bad debt shall give participants advance notice and a reasonable opportunity for payment. A provider, representative, employee, independent contractor, or agent of a pharmaceutical manufacturer shall not make co-payment for a participant. This subsection shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for Medicare and Medicaid Services does not approve the MO HealthNet state plan amendment submitted by the department of social services that would allow a provider to deny future services to an individual with uncollected co-payments, the denial of services shall not be allowed. The department of social services shall inform providers regarding the acceptability of denying services as the result of unpaid co-payments.

4. The MO HealthNet division shall have the right to collect medication samples from participants in order to maintain program integrity.

5. Reimbursement for obstetrical and pediatric services under subdivision (6) of subsection 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and services are

available under the state plan for MO HealthNet benefits at least to the extent that such care and services are available to the general population in the geographic area, as required under subparagraph (a)(30)(A) of 42 U.S.C. Section 1396a and federal regulations promulgated thereunder.

6. Beginning July 1, 1990, reimbursement for services rendered in federally funded health centers shall be in accordance with the provisions of subsection 6402(c) and Section 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations promulgated thereunder.

7. Beginning July 1, 1990, the department of social services shall provide notification and referral of children below age five, and pregnant, breast-feeding, or postpartum women who are determined to be eligible for MO HealthNet benefits under section 208.151 to the special supplemental food programs for women, infants and children administered by the department of health and senior services. Such notification and referral shall conform to the requirements of Section 6406 of P.L. 101-239 and regulations promulgated thereunder.

8. Providers of long-term care services shall be reimbursed for their costs in accordance with the provisions of Section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. Section 1396a, as amended, and regulations promulgated thereunder.

9. Reimbursement rates to long-term care providers with respect to a total change in ownership, at arm's length, for any facility previously licensed and certified for participation in the MO HealthNet program shall not increase payments in excess of the increase that would result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C. Section 1396a (a)(13)(C).

476 10. The MO HealthNet division may enroll qualified
477 residential care facilities and assisted living facilities,
478 as defined in chapter 198, as MO HealthNet personal care
479 providers.

480 11. Any income earned by individuals eligible for
481 certified extended employment at a sheltered workshop under
482 chapter 178 shall not be considered as income for purposes
483 of determining eligibility under this section.

484 12. If the Missouri Medicaid audit and compliance unit
485 changes any interpretation or application of the
486 requirements for reimbursement for MO HealthNet services
487 from the interpretation or application that has been applied
488 previously by the state in any audit of a MO HealthNet
489 provider, the Missouri Medicaid audit and compliance unit
490 shall notify all affected MO HealthNet providers five
491 business days before such change shall take effect. Failure
492 of the Missouri Medicaid audit and compliance unit to notify
493 a provider of such change shall entitle the provider to
494 continue to receive and retain reimbursement until such
495 notification is provided and shall waive any liability of
496 such provider for recoupment or other loss of any payments
497 previously made prior to the five business days after such
498 notice has been sent. Each provider shall provide the
499 Missouri Medicaid audit and compliance unit a valid email
500 address and shall agree to receive communications
501 electronically. The notification required under this
502 section shall be delivered in writing by the United States
503 Postal Service or electronic mail to each provider.

504 13. Nothing in this section shall be construed to
505 abrogate or limit the department's statutory requirement to
506 promulgate rules under chapter 536.

507 14. Beginning July 1, 2016, and subject to
508 appropriations, providers of behavioral, social, and

509 psychophysiological services for the prevention, treatment,
510 or management of physical health problems shall be
511 reimbursed utilizing the behavior assessment and
512 intervention reimbursement codes 96150 to 96154 or their
513 successor codes under the Current Procedural Terminology
514 (CPT) coding system. Providers eligible for such
515 reimbursement shall include psychologists.

208.437. 1. A Medicaid managed care organization
2 reimbursement allowance period as provided in sections
3 208.431 to 208.437 shall be from the first day of July to
4 the thirtieth day of June. The department shall notify each
5 Medicaid managed care organization with a balance due on the
6 thirtieth day of June of each year the amount of such
7 balance due. If any managed care organization fails to pay
8 its managed care organization reimbursement allowance within
9 thirty days of such notice, the reimbursement allowance
10 shall be delinquent. The reimbursement allowance may remain
11 unpaid during an appeal.

12 2. Except as otherwise provided in this section, if
13 any reimbursement allowance imposed under the provisions of
14 sections 208.431 to 208.437 is unpaid and delinquent, the
15 department of social services may compel the payment of such
16 reimbursement allowance in the circuit court having
17 jurisdiction in the county where the main offices of the
18 Medicaid managed care organization are located. In
19 addition, the director of the department of social services
20 or the director's designee may cancel or refuse to issue,
21 extend or reinstate a Medicaid contract agreement to any
22 Medicaid managed care organization which fails to pay such
23 delinquent reimbursement allowance required by sections
24 208.431 to 208.437 unless under appeal.

25 3. Except as otherwise provided in this section,
26 failure to pay a delinquent reimbursement allowance imposed

27 under sections 208.431 to 208.437 shall be grounds for
28 denial, suspension or revocation of a license granted by the
29 department of commerce and insurance. The director of the
30 department of commerce and insurance may deny, suspend or
31 revoke the license of a Medicaid managed care organization
32 with a contract under 42 U.S.C. Section 1396b(m) which fails
33 to pay a managed care organization's delinquent
34 reimbursement allowance unless under appeal.

35 4. Nothing in sections 208.431 to 208.437 shall be
36 deemed to effect or in any way limit the tax-exempt or
37 nonprofit status of any Medicaid managed care organization
38 with a contract under 42 U.S.C. Section 1396b(m) granted by
39 state law.

40 5. Sections 208.431 to 208.437 shall expire on
41 September 30, ~~[2021]~~ 2024.

208.480. Notwithstanding the provisions of section
2 208.471 to the contrary, sections 208.453 to 208.480 shall
3 expire on September 30, ~~[2021]~~ 2024.

338.550. 1. The pharmacy tax required by sections
2 338.500 to 338.550 shall expire ninety days after any one or
3 more of the following conditions are met:

4 (1) The aggregate dispensing fee as appropriated by
5 the general assembly paid to pharmacists per prescription is
6 less than the fiscal year 2003 dispensing fees reimbursement
7 amount; or

8 (2) The formula used to calculate the reimbursement as
9 appropriated by the general assembly for products dispensed
10 by pharmacies is changed resulting in lower reimbursement to
11 the pharmacist in the aggregate than provided in fiscal year
12 2003; or

13 (3) September 30, ~~[2021]~~ 2024.

14 The director of the department of social services shall
15 notify the revisor of statutes of the expiration date as

provided in this subsection. The provisions of sections 338.500 to 338.550 shall not apply to pharmacies domiciled or headquartered outside this state which are engaged in prescription drug sales that are delivered directly to patients within this state via common carrier, mail or a carrier service.

2. Sections 338.500 to 338.550 shall expire on September 30, ~~[2021]~~ 2024.

633.401. 1. For purposes of this section, the following terms mean:

(1) "Engaging in the business of providing health benefit services", accepting payment for health benefit services;

(2) "Intermediate care facility for the intellectually disabled", a private or department of mental health facility which admits persons who are intellectually disabled or developmentally disabled for residential habilitation and other services pursuant to chapter 630. Such term shall include habilitation centers and private or public intermediate care facilities for the intellectually disabled that have been certified to meet the conditions of participation under 42 CFR, Section 483, Subpart I;

(3) "Net operating revenues from providing services of intermediate care facilities for the intellectually disabled" shall include, without limitation, all moneys received on account of such services pursuant to rates of reimbursement established and paid by the department of social services, but shall not include charitable contributions, grants, donations, bequests and income from nonservice related fund-raising activities and government deficit financing, contractual allowance, discounts or bad debt;

25 (4) "Services of intermediate care facilities for the
26 intellectually disabled" has the same meaning as the term
27 services of intermediate care facilities for the mentally
28 retarded, as used in Title 42 United States Code, Section
29 1396b(w)(7)(A)(iv), as amended, and as such qualifies as a
30 class of health care services recognized in federal Public
31 Law 102-234, the Medicaid Voluntary Contribution and
32 Provider-Specific Tax Amendments of 1991.

33 2. Beginning July 1, 2008, each provider of services
34 of intermediate care facilities for the intellectually
35 disabled shall, in addition to all other fees and taxes now
36 required or paid, pay assessments on their net operating
37 revenues for the privilege of engaging in the business of
38 providing services of the intermediate care facilities for
39 the intellectually disabled or developmentally disabled in
40 this state.

41 3. Each facility's assessment shall be based on a
42 formula set forth in rules and regulations promulgated by
43 the department of mental health.

44 4. For purposes of determining rates of payment under
45 the medical assistance program for providers of services of
46 intermediate care facilities for the intellectually
47 disabled, the assessment imposed pursuant to this section on
48 net operating revenues shall be a reimbursable cost to be
49 reflected as timely as practicable in rates of payment
50 applicable within the assessment period, contingent, for
51 payments by governmental agencies, on all federal approvals
52 necessary by federal law and regulation for federal
53 financial participation in payments made for beneficiaries
54 eligible for medical assistance under Title XIX of the
55 federal Social Security Act, 42 U.S.C. Section 1396, et
56 seq., as amended.

57 5. Assessments shall be submitted by or on behalf of
58 each provider of services of intermediate care facilities
59 for the intellectually disabled on a monthly basis to the
60 director of the department of mental health or his or her
61 designee and shall be made payable to the director of the
62 department of revenue.

63 6. In the alternative, a provider may direct that the
64 director of the department of social services offset, from
65 the amount of any payment to be made by the state to the
66 provider, the amount of the assessment payment owed for any
67 month.

68 7. Assessment payments shall be deposited in the state
69 treasury to the credit of the "Intermediate Care Facility
70 Intellectually Disabled Reimbursement Allowance Fund", which
71 is hereby created in the state treasury. All investment
72 earnings of this fund shall be credited to the fund.
73 Notwithstanding the provisions of section 33.080 to the
74 contrary, any unexpended balance in the intermediate care
75 facility intellectually disabled reimbursement allowance
76 fund at the end of the biennium shall not revert to the
77 general revenue fund but shall accumulate from year to
78 year. The state treasurer shall maintain records that show
79 the amount of money in the fund at any time and the amount
80 of any investment earnings on that amount.

81 8. Each provider of services of intermediate care
82 facilities for the intellectually disabled shall keep such
83 records as may be necessary to determine the amount of the
84 assessment for which it is liable under this section. On or
85 before the forty-fifth day after the end of each month
86 commencing July 1, 2008, each provider of services of
87 intermediate care facilities for the intellectually disabled
88 shall submit to the department of social services a report
89 on a cash basis that reflects such information as is

necessary to determine the amount of the assessment payable for that month.

9. Every provider of services of intermediate care facilities for the intellectually disabled shall submit a certified annual report of net operating revenues from the furnishing of services of intermediate care facilities for the intellectually disabled. The reports shall be in such form as may be prescribed by rule by the director of the department of mental health. Final payments of the assessment for each year shall be due for all providers of services of intermediate care facilities for the intellectually disabled upon the due date for submission of the certified annual report.

10. The director of the department of mental health shall prescribe by rule the form and content of any document required to be filed pursuant to the provisions of this section.

11. Upon receipt of notification from the director of the department of mental health of a provider's delinquency in paying assessments required under this section, the director of the department of social services shall withhold, and shall remit to the director of the department of revenue, an assessment amount estimated by the director of the department of mental health from any payment to be made by the state to the provider.

12. In the event a provider objects to the estimate described in subsection 11 of this section, or any other decision of the department of mental health related to this section, the provider of services may request a hearing. If a hearing is requested, the director of the department of mental health shall provide the provider of services an opportunity to be heard and to present evidence bearing on the amount due for an assessment or other issue related to

123 this section within thirty days after collection of an
124 amount due or receipt of a request for a hearing, whichever
125 is later. The director shall issue a final decision within
126 forty-five days of the completion of the hearing. After
127 reconsideration of the assessment determination and a final
128 decision by the director of the department of mental health,
129 an intermediate care facility for the intellectually
130 disabled provider's appeal of the director's final decision
131 shall be to the administrative hearing commission in
132 accordance with sections 208.156 and 621.055.

133 13. Notwithstanding any other provision of law to the
134 contrary, appeals regarding this assessment shall be to the
135 circuit court of Cole County or the circuit court in the
136 county in which the facility is located. The circuit court
137 shall hear the matter as the court of original jurisdiction.

138 14. Nothing in this section shall be deemed to affect
139 or in any way limit the tax-exempt or nonprofit status of
140 any intermediate care facility for the intellectually
141 disabled granted by state law.

142 15. The director of the department of mental health
143 shall promulgate rules and regulations to implement this
144 section. Any rule or portion of a rule, as that term is
145 defined in section 536.010, that is created under the
146 authority delegated in this section shall become effective
147 only if it complies with and is subject to all of the
148 provisions of chapter 536 and, if applicable, section
149 536.028. This section and chapter 536 are nonseverable and
150 if any of the powers vested with the general assembly
151 pursuant to chapter 536 to review, to delay the effective
152 date, or to disapprove and annul a rule are subsequently
153 held unconstitutional, then the grant of rulemaking
154 authority and any rule proposed or adopted after August 28,
155 2008, shall be invalid and void.

156 16. The provisions of this section shall expire on
157 September 30, [2021] 2024.

 Section B. If any provision of section A of this act
2 or the application thereof to anyone or to any circumstance
3 is held invalid, the remainder of those sections and the
4 application of such provisions to others or other
5 circumstances shall not be affected thereby.